

Your supervisor(s) must complete the 'Supervisor Evaluation and Recommendation' form and send it directly to the

Upon receipt of your application portfolio, it will be reviewed. If the portfolio is not complete, you will be notified of any

Applicants failing the written examination will be required to submit the re-testing fee and a letter of intent to re-test in the

SEND COMPLETED APPLICATION, TRANSCRIPT(S), CURRENT JOB DESCRIPTION, AND FEE TO:

Revised 11/2/11

Application for Certification

A \$250.00 check or money order must accompany this application.

Submit to: CBADP, 3101 West 41st Street, Suite 205, Sioux Falls, SD 57105

I AM APPLYING FOR: _____ CCDC Level I _____ CCDC Level II _____ CCDC Level III

CERTIFICATION TRACK: ☐ Academic Track ☐ Experience Track

PERSONAL DATA:

Name: _____

First Middle Last Maiden

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Work Fax: _____

Email: _____

Social Security #: _____ Birth date: _____

CURRENT EMPLOYMENT:

YOU ARE REQUIRED TO SUBMIT A COPY OF YOUR CURRENT JOB DESCRIPTION

Agency Name: _____

Agency Mailing Address: _____

City: _____ State: _____ Zip: _____

Job Title: _____

Name of CCDC Supervisor: _____

STATISTICAL INFORMATION: (This information is used for statistical purposes only.)

Gender:
 _____Female
 _____Male

Ethnicity:

☐ African American

☐ American Indian

☐ Asian/Pacific Islander

☐ Caucasian

☐ Hispanic/Latino

☐ Other:

Educational and Academic Data

Official transcripts must be submitted for ALL education. If you have a college degree, you do not have to submit your high school transcripts.

High School Attended: _____

Date of Graduation: _____

GED: _____ Date: _____

Where Issued: _____

COLLEGE/UNIVERSITY (List all post secondary institutions attended):

Name of Institution	City, State	Degree(s) Earned	Date Conferred	Major Course of Study

SPECIALIZED EDUCATION DOCUMENTATION:

List all completed specialized educational courses. All courses must equal 3 or more semester credits and earn a "C" grade or higher.

Requirement	Name of College or University	Prefix - Course Number	Name of Course	Credit Hours	Term Taken	Grade
Example	FSU	HS 212	Study of Alcohol	3	Fall '95	B
*Intro to Alcohol Use and Abuse						
*Intro to Drug Use and Abuse						
*Foundations of Individual Counseling						
*Alcohol & Drug Group Counseling						
Alcohol & Drug Treatment Continuum						
*Professional Ethics for the CD Counselor						
Counseling Families with Alcohol or Other Drug Issues						
Cultural Competency OR Special Populations						
CD-Specific Elective						

*Courses required for CCDC Level I.

Work Experience Documentation

All experience must be specific to alcohol and drug counseling. List all relevant experience, beginning with your current place of employment. Verification must be received for all experience.

Applicant's Name: _____

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Supervisor: _____

Job Title: _____

Dates of Employment: From _____ To _____

Was the experience Full Time: _____ Part Time: _____ Volunteer: _____

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Supervisor: _____

Job Title: _____

Dates of Employment: From _____ To _____

Was the experience Full Time: _____ Part Time: _____ Volunteer: _____

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Supervisor: _____

Job Title: _____

Dates of Employment: From _____ To _____

Was the experience Full Time: _____ Part Time: _____ Volunteer: _____

Work Experience Verification

Applicant: All experience must be verified. Make a copy of this form for each agency where you completed work experience. Complete the top section and send the form to all agencies, employers, internship sites, etc. for verification of all work experience hours.

Applicant's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Job Title: _____

Dates of Employment: From _____ To _____

Was the experience Full Time: _____ Part Time: _____ Volunteer: _____

APPLICANT STOP HERE

THE FOLLOWING MUST BE COMPLETED BY THE AGENCY, EMPLOYER, INTERNSHIP SITE, ETC.

The applicant listed above is applying for certification as a chemical dependency counselor. Please verify the work experience for this individual and return this form directly to the Certification Board for Alcohol and Drug Professionals, 3101 West 41st Street, Suite 205, Sioux Falls, SD 57105. If the above information is not correct, please make changes and place your initials beside the changes.

I hereby attest that the above information is true and correct. This person was involved in the supervised counseling of diagnosed alcohol and drug abuse clients with the majority of their time spent in individual, group and/or family counseling; and, the remaining experience was related to the AODA Counselor Core Functions.

- ☐ I verify that the required hours of ongoing supervision have been met (i.e. for every ten hours of client contact, there has been a minimum of one hour of supervision between the clinical supervisor and the applicant).

Signature: _____

Name: _____

Name of Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Title: _____

Date: _____

Total **number of hours** of qualifying work experience: _____

Supervised Practical Training Hours

Provide a description of your 300 hours of supervised practical training. You must have at least 10 hours in each area and give specific examples of how you apply the principles in your professional practice.

Applicant's Name: _____

Supervisor's Name: _____

Agency where completed: _____

SCREENING	TOTAL HOURS:
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Description:

INTAKE	TOTAL HOURS:
---------------	---------------------

Description:

ORIENTATION:	TOTAL HOURS:
---------------------	---------------------

Description:

ASSESSMENT	TOTAL HOURS:
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Description:

Supervised Practical Training Hours (Continued)

TREATMENT PLANNING	TOTAL HOURS:
---------------------------	---------------------

Description:

COUNSELING	TOTAL HOURS:
-------------------	---------------------

Description:

CASE MANAGEMENT	TOTAL HOURS:
------------------------	---------------------

Description:

CRISIS INTERVENTION	TOTAL HOURS:
----------------------------	---------------------

Description:

CLIENT EDUCATION	TOTAL HOURS:
-------------------------	---------------------

Description:

Supervised Practical Training Hours (Continued)

REFERRAL	TOTAL HOURS:
-----------------	---------------------

Description:

REPORTS & RECORD KEEPING	TOTAL HOURS:
-------------------------------------	---------------------

Description:

CONSULTATION	TOTAL HOURS:
---------------------	---------------------

Description:

NOTE: You must document a minimum of 300 hours	GRAND TOTAL:
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I hereby certify that all of the above information is, to the best of my knowledge, true.

Signature of Supervisor

Date

Professional Code of Ethics

The Professional Code of Ethics applies equally to all Certified Chemical Dependency Counselors, Certified Prevention Specialists, Trainees, Interns, and individuals in the process of applying for certification. The Certification Board for Alcohol and Drug Professionals (CBADP) believes that all people have rights and responsibilities through every stage of human development. The goal of the CBADP is for addiction professionals to treat everyone with the dignity, honor, and reverence that is fitting to them.

The Professional Code of Ethical Conduct entitles human beings to the physical, social, psychological, spiritual, and emotional care necessary to meet their individual needs. All Certified Professionals, Trainees, and Interns have a responsibility to adhere to the following guiding principles:

1. That I have a total commitment to provide the highest quality of care for those people who seek my professional services.
2. That I will dedicate myself to the best interests of clients and assist them to help themselves.
3. That at all time, I shall maintain a professional relationship with clients.
4. That I will be willing, when I recognize that it is in the best interest of the client, to release or refer them to another program or professional.
5. That I shall adhere to the laws of confidentiality and professional responsibility of all records, materials, and knowledge concerning clients.
6. That I shall not in any way discriminate against clients or other professionals.
7. That I shall respect the rights and views of other professionals and clients.
8. That I shall maintain respect for institutional policies and management functions within agencies and institutions, but I will take the initiative toward improving such policies if it will best serve the interest of clients.
9. That I have a commitment to assess my own personal strengths, limitations, biases, and effectiveness on a continuing basis; that I shall continuously strive for self-improvement and professional growth through further education and/or training.
10. That I have a responsibility for appropriate behavior in all areas of my professional and private life, and to provide a positive role model especially in regard to the personal use of alcohol and other drugs.
11. That I have a responsibility to myself, my clients, and other associates to maintain my physical and mental health.
12. That I respect the client's right to worship or not, according to their conscience and beliefs, and that I will not impose my own beliefs, values, or standards upon them.
13. That I have a professional responsibility to understand and appreciate different cultures for persons whom are or may be in my care or are recipients of my professional services. I will demonstrate sensitivity to cultural differences in my professional practices.
14. That I have a regard for an individual's needs and rights to equal protection and due process under the laws of the State of South Dakota.

Private conduct is a personal matter, except when such conduct compromises the fulfillment of professional responsibilities or may endanger the health or safety of clients who are or may be under my care. As a professional, I have a responsibility to report, whether obvious or perceived, any ethical violations or concerns related to my peers.

I understand and subscribe to the preceding professional code of ethics and understand that any violation of the principles will be grounds for disciplinary action and sanctions.

☐

By checking this box, I hereby attest that I have read and will comply with the 2004 Codes of Ethics and Standards of Practice of the Certification Board for Alcohol and Drug Professionals.

The Codes of Ethics can be viewed and/or printed at: www.dhs.sd.gov/brd/CBADP. Applicants who have not read the Codes of Ethics and have not checked the box above will not be granted certification by the CBADP.

Signature of Applicant

Date

Authorization and Release of Information

I hereby attest that I have not been convicted of, plead guilty to, or plead no contest to, any felony, or to any crime involving moral turpitude or like offense, including any crimes of offenses where imposition of sentence was suspended.

I hereby understand that being convicted of, pleading guilty to, or pleading no contest to, any felony or crime of moral turpitude in any state, federal, foreign jurisdiction, tribal, or military court or tribunal must be disclosed to the Certification Board for Alcohol and Drug Professionals (Board), and that this information, or failure to fully disclose this information, may, standing alone, provide sufficient grounds to deny, revoke, suspend, or refuse certification, recertification, trainee recognition, trainee renewal, or student internship status.

I hereby understand that my obligation to disclose whether I have been convicted of, plead guilty to, or plead no contest to, any felony or crime of moral turpitude in any state, federal, foreign jurisdiction, tribal, or military court or tribunal includes any crimes or offenses where imposition of sentence was suspended.

I hereby attest that I am not required to register as a sex offender.

I confirm that I have never had an application denied, had my professional license revoked or suspended, or been sanctioned or disciplined by this or any other certifying or licensing professional board or authority, public or private. If I have had an application denied, had my professional license revoked or suspended, or been sanctioned or disciplined by this or any other certifying or licensing professional board or authority, public or private, I understand that I am required to provide that information to the Board, in writing.

I hereby authorize the Board to release to any agency, facility, organization, or individual any and all information necessary for verification of credentials.

I hereby authorize any agency, facility, organization, or individual contacted by the Board to release any and all information and documents requested and waive any and all confidentiality or privilege provided by state, federal, foreign jurisdictions, tribal, or military statute, law, or rule. I understand that the Board reserves the right to request further information or documentation to evaluate and verify my application, qualifications, education, training, moral character, and professional competence.

I hereby release and hold harmless the Certification Board for Alcohol and Drug Professionals; its Board Members- past, present and future; its attorneys- past, present, and future; its agents, representatives and employees- past, present and future; as well as and any agency, facility, organization, or individual providing information or documents to the Board pursuant to my application.

I hereby understand that failing to provide accurate, full, and complete responses to the questions and requests for information in my application may, in the Board's discretion and judgment, cause it to deny, suspend, or revoke certification, trainee recognition, or student internship status and may result in administrative, civil, or criminal legal action.

I hereby certify that the information contained herein is correct and true, and that I have read and completely understand the Authorization and Release of Information.

Please print your name below as you would like it to appear on your certificate.

Printed name: _____

Signature of Applicant

Date

Statement of Felony Charges

All felony charges must be disclosed to the Certification Board for Alcohol and Drug Professionals. Felony charges include being convicted of, pleading guilty to, or pleading no contest to, any felony or crime of moral turpitude in any state, federal, foreign jurisdiction, tribal, or military court or tribunal and includes any crimes or offenses where imposition of sentence was suspended. Failure to fully disclose this information, may, standing alone, provide sufficient grounds to deny, revoke, suspend, or refuse certification, recertification, trainee recognition, trainee renewal, or student internship status.

I have had felony charges filed against me. Yes _____ No _____

If you answered 'yes', please provide detailed information below:

Date charges were filed: _____

The Disposition:

The Sentence or Fine:

State why you feel this felony charge does not affect your ability to effectively work in the chemical dependency or prevention specialist field:

Signature of Applicant

Date

SUPERVISOR EVALUATION AND RECOMMENDATION

INSTRUCTIONS FOR THE APPLICANT: Give or mail this form directly to your supervisor(s) after you have filled in the bottom portion of this page. If your present supervisor has been supervising you for less than six (6) months, make a copy of this form and provide it to your immediate and past supervisors.

CONFIDENTIAL

Dear Supervisor:

The individual listed below is applying to the Certification Board for Alcohol & Drug Professionals (CBADP) for certification as a Chemical Dependency Counselor. The information requested here is an essential part of the Board's evaluation of the competence of the applicant and must be on file before the application can be processed.

The CBADP believes that your observation will provide a more complete and accurate impression of the knowledge and skills of the applicant than is available from other sources. Your evaluation and recommendation, plus recommendations from other professionals, and the data furnished by the applicant, will be used in determining eligibility for certification. The process can only be as good as you and the others make it, by careful and truthful reporting.

Please return the completed evaluation **DIRECTLY TO:**

CBADP
3101 West 41st Street, Suite 205
Sioux Falls, SD 57105

APPLICANT'S NAME: _____ DATE: _____

SUPERVISOR'S NAME: _____

SUPERVISOR'S TITLE & CREDENTIALS: _____

AGENCY NAME: _____

AGENCY ADDRESS: _____

AGENCY PHONE: _____

SUPERVISOR EVALUATION AND RECOMMENDATION (Continued)

APPLICANT'S NAME: _____

The following items represent the skills needed by a Chemical Dependency Counselor. Evaluate the applicant for their abilities in each area. Mark the rating most descriptive of the individual's demonstrated skills. Use N/O (not observed) ONLY if you have never observed nor have any knowledge of the applicant's skill in that area. Please use the following rating scale:

1 – POOR 2 – NEEDS IMPROVEMENT 3 – ACCEPATBLE
4 – GOOD 5 – EXCELLENT

COUNSELOR SKILL AREAS	RATING	N/O
SCREENING: Determining appropriate and timely services for clients with knowledge of his/her problems and their intensity.	1 2 3 4 5	
CLIENT INTAKE: The process of collecting client information for assessment purposes.	1 2 3 4 5	
CLIENT ORIENTATION: Providing clients with general goals, rules, services, rights, etc. of program services.	1 2 3 4 5	
CLIENT ASSESSMENT: Identification and evaluation of information to determine appropriate treatment services.	1 2 3 4 5	
CHEMICAL DEPENDENCY EVALUATION: Knowledge and application of the major theories and stages of addiction and the symptomatology of chemical dependency for assessment of clients.	1 2 3 4 5	
TREATMENT PLANNING: Defining problems and needs, establishing long- and short-term goals and developing a treatment process and the resources to be used.	1 2 3 4 5	
COUNSELING SKILLS: (Individual, Group, Family) The utilization of special skills to assist in assessing client's problems and facilitating appropriate changes.	1 2 3 4 5	
CASE MANAGEMENT: The coordination of services, agencies, resources or people within a planned framework of action for the achievement of established goals.	1 2 3 4 5	
CRISIS INTERVENTION: Assessing, defining and responding to the needs during acute, emotional, and/or physical distress.	1 2 3 4 5	
CLIENT EDUCATION: Provision of information concerning alcohol and other drug abuse implications, available services, and resources.	1 2 3 4 5	
REFERRAL: Identifying and limiting of appropriate services, familiarization of community and state resources available with demonstration of the referral process, including confidentiality requirements.	1 2 3 4 5	
REPORT AND RECORD KEEPING: Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries, and other client-related data.	1 2 3 4 5	
CONSULTATION: Relating with agency staff and other professionals to assure comprehensive, quality care for clients.	1 2 3 4 5	
PROFESSIONAL & ETHICAL RESPONSIBILITIES: A counselor's ability to adhere to generally accepted ethical and behavioral standards of conduct and continuing professional development.	1 2 3 4 5	

SUPERVISOR EVALUATION AND RECOMMENDATION (Continued)

Are you involved in the administration/management of the program where you are employed?

_____ No

_____ Yes, limited to clinical aspects (i.e., supervision of counselors).

_____ Yes, limited to administrative responsibilities.

_____ Yes, both _____% clinical and _____% administrative.

How long have you supervised this applicant? _____

For what period of time, while under your supervision, was chemical dependency counseling the major part of this applicant's responsibilities?

From: _____ To: _____

Describe those activities: _____

Comments and/or additional information you feel may be pertinent: _____

I hereby certify that I have been in a position to observe and have first-hand knowledge of the

applicant's work at: _____

(Name of work setting)

_____ I recommend this applicant for certification.

_____ I do not recommend this applicant certification.

I hereby certify that all of the above information is, to the best of my knowledge, true.

Signature of Supervisor

Date

Professional Recommendation Form

Provide this form to a professional and/or academic colleague who is acquainted with your chemical dependency counseling experience. Provide a pre-addressed, stamped envelope so the form can be mailed directly to the CBADP Administrative Office.

NOTE: ANY INDIVIDUAL WHO HAS COMPLETED THE 'SUPERVISOR EVALUATION AND RECOMMENDATION' FORM FOR THIS APPLICANT MAY NOT SUBMIT A 'PROFESSIONAL RECOMMENDATION' FORM.

PART I - TO BE COMPLETED BY THE APPLICANT

Complete the information below. Give this form to a professional who is acquainted with your work performance and abilities. Be sure to provide the individual with a pre-addressed, stamped envelope so the form can be mailed directly to the CBADP.

Name of Applicant: _____

Address: _____

City: _____ State: _____ Zip: _____

I understand that this recommendation will be used in determining my eligibility for certification and is a character reference. Therefore, I agree and understand that I will not be entitled to this information under any circumstance.

Applicant's signature

Date

PART II - TO BE COMPLETED BY A PROFESSIONAL OR ACADEMIC ACQUAINTANCE

The person listed above has applied for certification as an Alcohol and Drug Counselor. The signature above authorizes you to complete this form. Your assessment will assist the Board of Directors in determining the applicant's appropriateness for certification. A fair and candid report is essential. Therefore, we ask for careful ratings and comments about character and ability. All information submitted will be viewed as confidential and will not be available to the applicant.

YOUR NAME: _____

POSITION/TITLE: _____

BUSINESS ADDRESS: _____

DAYTIME TELEPHONE #: _____

HOW LONG HAVE YOU KNOWN THE APPLICANT: _____

IN WHAT CAPACITY: _____

Professional Recommendation Form (Continued)

Please rate the candidate by circling the most accurate response. Use “Don’t Know” ONLY if you have never observed or have absolutely no knowledge of the respective variable.

COUNSELOR SKILL AREAS	Poor-Excellent	Don’t Know
Breadth of knowledge in alcohol and other drug abuse	1 2 3 4 5	
Breadth of knowledge in the twelve core functions	1 2 3 4 5	
Relationship ability	1 2 3 4 5	
Communication skills	1 2 3 4 5	
Sense of responsibility & adherence to state & federal confidentiality regulations	1 2 3 4 5	
Empathy / understanding	1 2 3 4 5	
Openness / genuineness	1 2 3 4 5	
Honesty / integrity	1 2 3 4 5	
Cooperation with others	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients	1 2 3 4 5	
Self-assessment / insight	1 2 3 4 5	
Ability to be objective	1 2 3 4 5	
Flexibility / adaptability	1 2 3 4 5	
Emotional stability	1 2 3 4 5	
Crisis problem solving	1 2 3 4 5	
Counseling abilities & competencies	1 2 3 4 5	

Please provide a written overall assessment of the candidate as a Counselor. Comment on the intellectual and personal assets and/or liabilities that would affect the person’s professional practice in alcohol and drug abuse counseling.

Signature

Date

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POSITION/TITLE: _____

BUSINESS ADDRESS: _____

DAYTIME TELEPHONE #: _____

HOW LONG HAVE YOU KNOWN THE APPLICANT: _____

IN WHAT CAPACITY: _____

Professional Recommendation Form (Continued)

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Openness / genuineness	1 2 3 4 5	
Honesty / integrity	1 2 3 4 5	
Cooperation with others	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients	1 2 3 4 5	
Self-assessment / insight	1 2 3 4 5	
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POSITION/TITLE: _____

BUSINESS ADDRESS: _____

DAYTIME TELEPHONE #: _____

HOW LONG HAVE YOU KNOWN THE APPLICANT: _____

IN WHAT CAPACITY: _____

Professional Recommendation Form (Continued)

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Sense of responsibility & adherence to state & federal confidentiality regulations	1 2 3 4 5	
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Honesty / integrity	1 2 3 4 5	
Cooperation with others	1 2 3 4 5	
Ability to recognize and set appropriate limits with clients	1 2 3 4 5	
Self-assessment / insight	1 2 3 4 5	
Ability to be objective	1 2 3 4 5	
Flexibility / adaptability	1 2 3 4 5	
Emotional stability	1 2 3 4 5	
Crisis problem solving	1 2 3 4 5	
Counseling abilities & competencies	1 2 3 4 5	

Please provide a written overall assessment of the candidate as a Counselor. Comment on the intellectual and personal assets and/or liabilities that would affect the person’s professional practice in alcohol and drug abuse counseling.

Signature

Date

TWELVE CORE FUNCTIONS OF THE ALCOHOL AND DRUG ABUSE COUNSELOR AND GLOBAL CRITERIA

All applicants for Chemical Dependency Certification must document 300 hours of supervised practical training in the following Twelve Core Functions, with a minimum of 10 hours in each core function. The twelve core functions represent a specific entity and although they may overlap, depending on the nature of the Counselor's practice the Counselor must be able to demonstrate competency in each core function and global criteria area.

SCREENING: The process by which a client is determined to be appropriate and eligible for admission to a particular program.

Global Criteria

1. Evaluate psychological, social and physiological signs and symptoms of alcohol and other drug use and abuse.
2. Determine the client's appropriateness for admission or referral.
3. Determine the client's eligibility for admission or referral.
4. Identify any coexisting conditions (medical, psychiatric, physical, etc.) that indicate a need for additional professional assessment and/or services.
5. Adhere to applicable laws, regulations and agency policies governing alcohol and other drug abuse services.

This function requires that the counselor consider a variety of factors before deciding whether or not to admit the potential client for treatment. It is imperative that the counselor use appropriate diagnostic criteria to determine whether the applicant's alcohol or other drug use constitutes abuse. All counselors must be able to describe the criteria they use and demonstrate their competence by presenting specific examples of how the use of alcohol and other drugs has become dysfunctional for a particular client.

The determination of a particular client's appropriateness for a program requires the counselor's judgment and skill and is influenced by the program's environment and modality (i.e., inpatient, outpatient, residential, pharmacotherapy, detoxification, or day care). Important factors include the physical condition of the client, outside supports/resources, previous treatment efforts, motivation and the philosophy of the program.

The eligibility criteria are generally determined by the focus, target population and funding requirements of the counselor's program or agency. Many of the criteria are easily ascertained. These may include the client age, gender, place of residence, legal status, veteran status, income level and the referral source. Allusion to following agency policy is a minimally acceptable statement.

If the applicant (client) is found ineligible or inappropriate for the program, the counselor should be able to suggest an alternative.

INTAKE: The administrative and initial assessment procedures for admission to a program.

6. Complete required documents for admission to the program.
7. Complete required documents for program eligibility and appropriateness.
8. Obtain appropriately signed consents when soliciting from or providing information to outside sources to protect client confidentiality and rights.

The intake usually becomes an extension of the screening, when the decision to admit is formally made and documented. Much of the intake process includes the completion of various forms. Typically, the client and counselor fill out an admission or intake sheet, document the initial assessment, complete appropriate releases of information, collect financial data, sign consent for treatment and assign the primary counselor.

ORIENTATION: Describing to the client the following: general nature and goals of the program; rules governing client conduct and infractions that can lead to disciplinary action or discharge from the program; in a non-residential program, the hours during which services are available; treatment costs to be borne by the client, if any, and client's rights.

Global Criteria:

9. Provide an overview to the client by describing program goals and objectives for client care.
10. Provide an overview to the client by describing program rules, and client obligations and rights.
11. Provide an overview to the client of the programs operations.

The orientation may be provided before, during and/or after the client's screening and intake. It can be conducted in an individual, group or family context. Portions of the orientation may include other personnel for certain specific parts of the treatment, such as medication.

ASSESSMENT: The procedures by which a counselor/program identifies and evaluates an individual's strengths, weaknesses, problems and needs for the development of a treatment plan.

Global Criteria:

12. Gather relevant history from client including but not limited to alcohol and other drug abuse using appropriate interview techniques.
13. Identify methods and procedures for obtaining corroborative information from significant secondary sources regarding client's alcohol and other drug abuse and psycho-social history.
14. Identify appropriate assessment tools.
15. Explain to the client the rationale for the use of assessment techniques in order to facilitate understanding.
16. Develop a diagnostic evaluation of the client's substance abuse and any coexisting conditions based on the results of all assessments in order to provide an integrated approach to treatment planning based on the client's strengths, weaknesses, and identified problems and needs.

Although assessment is a continuing process, it is generally emphasized early in treatment. It usually results from a combination of focused interviews, testing and/or record reviews.

The counselor evaluates major life areas (i.e., physical, health, vocational development, social adaptation, legal involvement and psychological functioning) and assesses the extent to which alcohol or drug use has interfered with client's functioning in each of these areas. The result of this assessment should suggest the focus for treatment.

TREATMENT PLANNING: Process by which the counselor and the client identify and rank problems needing resolution; establish agreed upon immediate and long term goals and decide upon a treatment process and the resource to be utilized.

Global Criteria:

17. Explain assessment results to the client in an understandable manner.
18. Identify and rank problems based on individual client needs in the written treatment plan.
19. Formulate agreed upon immediate and long-term goals using behavioral terms in the written treatment plan.
20. Identify the treatment methods and resources to be utilized as appropriate for the individual client.

The treatment contract is based on the assessment and is a product of a negotiation between the client and counselor to assure that the plan is tailored to the individual's needs. The language of the problem, goal and strategy statements should be specific, intelligible to the client and expressed in behavioral terms. The statement of the problem concisely elaborates on a client and counselor to determine progress in treatment. The plan or strategy is a specific activity that links the problem with the goal. It describes the services, who will provide them, where they will be provided and at what frequency.

Treatment planning is a dynamic process and the contracts must be regularly reviewed and modified as appropriate.

COUNSELING: (Individual, Group and Significant Others.) The utilization of special skills to assist individuals, families, or groups in achieving objectives through exploration of a problem and its ramifications; examination of attitudes and feelings; consideration of alternative solutions and decision making.

Global Criteria:

21. Select the counseling theory(ies) that apply.
22. Apply technique(s) to assist the client, group, and/or family in exploring problems and ramifications.
23. Apply techniques to assist the client, group, and/or family in examining the client's behavior, attitudes, and/or feelings if appropriate in the treatment setting.
24. Individualize counseling in accordance with cultural, gender and life-style differences.
25. Interact with the client in an appropriate therapeutic manner.
26. Elicit solutions and decisions from the client.
27. Implement the treatment plan.

Counseling is basically a relationship in which the counselor helps the client mobilize resources to resolve his/her problem and/or modify attitudes and values. The counselor must be able to demonstrate a working knowledge of various counseling approaches. These methods may include Reality Therapy, Transactional Analysis, Strategic Family Therapy, Client-Centered Therapy, etc. Further, the counselor must be able to explain the rationale for using a specific skill for the particular client. For example, a behavioral approach might be suggested for clients

who are resistant, manipulative and have difficulty anticipating consequences and regulating impulses. On the other hand, a cognitive approach may be appropriate for a client who is depressed, yet insightful and articulate.

Also, the Counselor should be able to explain his/her rationale for choosing a counseling skill in an individual, group or significant other context. Finally, the counselor should be able to explain why a counseling approach or context changes during treatment.

CASE MANAGEMENT: Activities that bring services, agencies, resources or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contracts.

Global Criteria:

28. Coordinate services for client care.
29. Explain the rationale of case management activities to the client.

Case management is the coordination of a multiple services plan. By the time many alcohol and other drug abusers enter treatment they tend to manifest dysfunction in a variety of areas. For example, a heroin addict may have hepatitis, lack job skills and have pending criminal charges. In this case, the counselor might monitor his medical treatment, make a referral to a vocational rehabilitation program and communicate with representatives of the Criminal Justice system.

The client may also be receiving other treatment services, such as family therapy and pharmacotherapy, within the same agency. These activities must be integrated into the treatment plan and communication must be maintained with the appropriate personnel.

CRISIS INTERVENTION: Those services that respond to an alcohol and/or other drug abuser's needs during acute emotional and/or physical distress.

Global Criteria:

30. Recognize the elements of the client's crisis.
31. Implement an immediate course of action appropriate to the crisis.
32. Enhance overall treatment by utilizing crisis events.

A crisis is a decisive, crucial event in the course of treatment that threatens to compromise or destroy the rehabilitation effort. These crises may be directly related to alcohol or drug use (i.e., overdose or relapse) or indirectly related. The latter might include the death of a significant other, separation/divorce, arrest, suicidal gestures, a psychotic episode or outside pressure to terminate treatment. If no specific crisis is presented in the Written Case, rely on and describe a past experience with a client. Describe the overall picture before, during and after the crisis.

It is imperative that the counselor be able to identify the crisis when they surface, attempt to mitigate or resolve the immediate problem and use the negative events to enhance the treatment efforts, if possible.

CLIENT EDUCATION: Provision of information to individuals and groups concerning alcohol and other drug abuse, the implications of, and the available services and resources.

Global Criteria:

33. Present relevant alcohol and other drug use/abuse information to the client through formal and/or informal processes.
34. Present information about available alcohol and other drug services and resources.

Client education is provided in a variety of ways. In certain inpatient and residential programs, for example, a sequence of formal classes may be conducted using a didactic format with reading materials and films. On the other hand, an outpatient counselor may provide relevant information to the client individually and informally. In addition to alcohol and drug information, client education may include a description of self-help groups and other resources that are available to the clients and their families. The applicant must be competent in providing a specific example of the type of education provided to the client and the relevance to the case.

REFERRAL: Identifying the needs of the client that cannot be met by the counselor or agency and assisting the client to utilize the support systems and community resources available.

Global Criteria:

35. Identify need(s) and/or problem(s) that the agency and/or counselor cannot meet.
36. Explain the rationale for the referral to the client.
37. Match client needs and/or problems to appropriate resources.
38. Adhere to applicable laws, regulations and agency policies governing procedures related to the protection of the client's confidentiality.
39. Assist the client in utilizing the support systems and community resources available.

In order to be competent in this function, the counselor must be familiar with community resources, both alcohol and drug and others, and be aware of the limitations of each service and if the limitations could adversely impact the client. In addition, the counselor must be able to demonstrate a working knowledge of the referral process, including the confidentiality requirements and outcomes of the referral.

Referral is obviously closely related to case management when integrated into the initial and ongoing treatment plan. It also includes, however, aftercare or discharge planning referrals that take into account the continuum of care.

REPORTS AND RECORD KEEPING: Charting the results of the assessment and treatment plan, writing reports, progress notes, discharge summaries and other client-related data.

Global Criteria:

40. Prepare reports and relevant records integrating available information to facilitate the continuum of care.
41. Chart pertinent ongoing information pertaining to the client.
42. Utilize relevant information from written documents for client care.

The report and record-keeping function is extremely important. It benefits the counselor by documenting the client's progress in achieving his or her goals. It facilitates adequate communication between co-workers. It assists the counselor's supervision providing timely feedback. It is valuable to other programs that may provide services to the client at a later date. It can enhance the accountability of the program to its licensing/funding sources. Ultimately, if performed properly, it can enhance the client's entire treatment experience. The applicant must prove personal action in regard to the report and record keeping function.

CONSULTATION WITH OTHER PROFESSIONALS IN REGARD TO CLIENT TREATMENT SERVICES:

Relating with in-house staff or outside professionals to assure comprehensive, quality care for the client.

Global Criteria:

43. Recognize issues that are beyond the counselor's base of knowledge and/or skills.
44. Consult with appropriate resources to ensure the provision of effective treatment services.
45. Adhere to applicable laws, regulations and agency policies governing the disclosure of client identifying data.
46. Explain the rationale for the consultation to the client, if appropriate.

Consultations are meetings for discussions, decision-making and planning. The most common consultation is the regular in-house staffing in which client cases are reviewed with other members of the treatment team. Consultations also can be conducted in individual sessions with the supervisor, other counselors, psychologists, physicians, probation officers and other service providers connected with the client's case.

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REQUEST FOR SPECIAL EXAMINATION ACCOMMODATIONS

If you have a disability covered by the Americans with Disabilities, please complete this page and have the appropriate professional complete the "Documentation of Disability-Related Needs" (page 2) so your accommodations for testing can be processed efficiently. The information you provide and any documentation regarding your disability and your need for accommodations in testing will be treated with strict confidentiality.

Candidate Information Social Security # _____ - _____ - _____

Exam Date: _____ Exam Location: _____

Name: _____

Home Address: _____

City/State/Zip: _____

Daytime Telephone Number: _____

Email: _____

Special Accommodations

I request special accommodations for: _____ the AODA Counselor Examination
_____ the Prevention Specialist Examination

Please provide (check all that apply):

_____ Special seating or other physical accommodations

_____ Reader

_____ Large print exam booklet

_____ Extended testing time (time and a half)

_____ Distraction-free room

_____ Other special accommodations (please specify)

Comments: _____

Signed: _____ Date: _____

Complete page 1 and 2 of this form and return to:
CBADP, 3101 West 41st Street, Suite 205, Sioux Falls, SD 57105
at least 60 days prior to the exam date.

DOCUMENTATION OF DISABILITY-RELATED NEEDS

Please have this section completed by an appropriate professional (physician, psychologist, psychiatrist) to ensure that the CBADP is able to provide the required exam accommodations.

Professional Documentation

I have known _____ since ____/____/____ in my
Exam Candidate Date

capacity as a _____.
Professional Title

The candidate discussed with me the nature of the exam to be administered. It is my professional opinion that, because of this candidate's disability described below, he/she should be accommodated by providing the special arrangements listed on page 1 of this form.

Description of Disability: _____

Signed: _____ Title: _____

Printed Name: _____

Name of Agency: _____

Address: _____

City/State/Zip: _____

Telephone Number: _____ Email: _____

License Number: _____ Date: _____
(if applicable)

Complete page 1 and 2 of this form and return to:
CBADP, 3101 West 41st Street, Suite 205, Sioux Falls, SD 57105
at least 60 days prior to the exam date.